AMA NEW SOUTH WALES

29 April 2024

The Hon. Emma Hurst MLC
Chair, Select Committee on Birth Trauma
NSW Parliament

By email: BirthTrauma@parliament.nsw.gov.au

Dear Ms Hurst

I refer to the question provided on notice to Dr Eveline Staub when she appeared before the Committee on 8 April 2024.

During the Committee hearing, you, in your capacity as Chair, and Dr Staub had the following exchange:

> *"**The CHAIR**: The other thing that has come up a lot is the dialogue. It's not specific to this session or your evidence, but something that's constantly coming up throughout this inquiry is this whole idea that there are two patients. My understanding from a lot of the individuals and mothers that are coming forward is that obviously they want their baby prioritised but they're also recognising that, when the baby is prioritised and they aren't, that creates the trauma and that causes long-term impacts for that really important relationship in those early stages straight after birth. Obviously, sometimes that's completely unavoidable. I think what a lot of these individual mothers are saying is that we need to make sure that they're treated equally rather than only prioritising one patient over the other. How do we get there, in your area, to make sure that there's no accidental trauma that can affect that bond? What are things that are avoidable that we need to change in the system?*
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> ***EVELINE STAUB**: I'm not sure we know that answer, to be very honest. In the situation, you are dealing with the mum who is there physically and the baby who is not yet born and we can only get indirect signals. To get those priorities right, I would think, is extremely difficult to do. I'm not sure I can make any recommendations.*
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> ***The CHAIR**: I'm happy for you to take it on notice, if you want to think about it.*
>
> ***EVELINE STAUB**: Yes, I could do that. I don't think I can give you an answer right now, so I might take it on notice.*

AMA (NSW) thanks the Chair for the opportunity to provide a considered response to the question posed.

This further submission is to be read together with AMA (NSW)'s submissions dated 15 August 2023 and 20 February 2024.

I acknowledge Dr Eveline Staub and Dr Kathryn Austin both of whom continue to given generously of their expertise and time to inform the evidence provided to the Committee by AMA (NSW).

The response to the question, is unavoidably lengthy. As has been demonstrated throughout the Committee's inquiry, the issues involved are complex.

1. Background

1.1 Obstetrics is one of the only fields in medicine in which decisions made in the care of one person (the pregnant woman) can immediately affect the outcome of another (the fetus).

1.2 In that regard, it is universally accepted that the fetus is completely reliant on the mother to survive in utero and as such, it has been described as representing the *"utmost of vulnerable populations"*[1].

1.3 From an ethical and/or moral standpoint, a medical practitioner is arguably subject to equitable duties to treat and care for both the pregnant woman and the fetus.

1.4 One might expect that if asked, most pregnant women would indicate both agreement and support for the above proposition or, as expressed by the Chair, might even express a desire for their baby's health to be prioritised above their own.

1.5 There are, however, instances where to do either of the above would create a potential conflict in the maternal-fetal relationship and place the medical practitioner in an extremely difficult predicament.

2. Legal Principles

Patient autonomy

2.1 It is a well-established legal principle, consistently upheld by Australian courts, that an adult patient with capacity has the right to refuse medical treatment for any reason whatsoever, even if the consequence of that decision is that the person will die[2]. This principle of patient autonomy extends to all medical treatment, including that which may be recommended to a pregnant woman for fetal benefit. [3]

Legal status of the fetus

2.2 It is similarly well established that a fetus is not recognised as a legal person, with rights of its own, until it is born. In other words, whilst the fetus is in utero, it does not have any separate interests capable of being considered by the court before birth[4].

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[1] Management of Pregnant Patients Who Refuse Medically Indicated Cesarean Delivery, Neha A Deshpande, BA and Corrina M Oxford, MC, Reviews in Obstetrics & Gynecology, 2012; 5(3-4): e144-e150

[2] *Hunter and New England Area Health Service v A* [2009] NSWSC 761 and *Brightwater Care Group v Rossiter* [2009] WASC 229)(41, 42).

[3] NSW Health Consent to Medical and Healthcare Treatment Manual, Section 6, Page 28

[4] *Watt v Rama* [1972] V.R. 353 and *X and y (by her Tutor X) v Pal* (1991) 23 NSWLR 26

3. Application of legal principles to the maternal-fetal relationship

3.1 The application of the above legal principles to the specific circumstances of a pregnant woman declining treatment recommended for fetal benefit has rarely been considered by the courts.[5]

3.2 While we have not identified a single published decision of an Australian Court where such a scenario has been established, guidance may be drawn from the following decisions of the English courts, which have been recognised as largely settling the matter in the UK jurisdiction:

(a) *Re MB* [1997] EWCA Civ 3093: The Court found that a fetus had no rights of its own until birth and held that a competent woman with capacity may decline medical intervention, even though the *"consequence may be the death or serious handicap of the child."*[6]

(b) *St George's Health Care NHS Trust v S; Rv Collins and others, ex part S* [1998] 3 All ER 673: The Court held that:

> *"An unborn child, although human and protected by the law in a number of different ways, is not a separate person from its mother. Its need for medical assistance does not prevail over her rights, and she is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it."*[7]

3.3 Given these decisions, it is unlikely that an Australian court, confronted with a conflict in the maternal-fetal relationship, would authorise medical treatment on a competent, non-consenting pregnant woman to preserve the life of her fetus.

3.4 This position is reflected in NSW Health's *Consent to Medical and Healthcare Treatment Manual*, which sets out the following process a medical practitioner must follow when a pregnant woman refuses treatment in circumstances that may pose a serious risk to the welfare of the fetus:

> *"Section 10.2.4 Refusal of recommended treatment in a maternity setting.*
>
> *…the Health Practitioner should clearly advise the woman of the risks of refusing the treatment and, where possible, obtain written acknowledgement of the provision of information by the Health Practitioner of the risks and the refusal of the recommended treatment."*[8]

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[5] Curnow K. A right to choose how to live: the Australian common law position on refusals of care. J Med Law. 2014;22(2):398-414, as referenced in Queensland Health, Guideline: Partnering with the woman who declines recommended maternity care.

[6] Paragraph 30, *Re MB* [1997] EWCA Civ 3093

[7] Paragraph 45, *St George's Health Care NHS Trust v S; Rv Collins and others, ex part S* [1998] 3 All ER 673

[8] NSW Health: Consent to Medical and Healthcare Treatment Manual, Section 10.2.4, Page 59

3.5 Similarly, the guidelines and policies developed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (**RANZCOG**), NSW Health, Queensland Health and the AMA[9] acknowledge that, in circumstances where a conflict arises in the maternal-fetal relationship, the woman's informed decision must be respected at all times, even if it is to the detriment of the fetus.

3.6 For completeness, in emergency situations, or circumstances where the woman lacks capacity to make an informed decision, such guidelines and policies provide that medical treatment to preserve the woman's life and the fetus' life may be initiated without her consent, subject to the consideration of any previous clear direction by the woman to the contrary.

4. Priorities in the maternal-fetal relationship

4.1 From an ethical and/or moral viewpoint, it might be considered that the rights of the pregnant woman and her fetus are to be treated equally. At law, this is not the established position.

4.2 The guidelines and policies referred to in paragraph 3.5 above indicate that when confronted with a conflict in the maternal-fetal relationship, accepted clinical practice involves medical practitioners:

(a) Providing clear and evidence-based advice and information to a pregnant woman regarding the risks and benefits of the recommended treatment, possible alternative treatments, and no treatment, both for herself and the fetus, with such advice preferably being given during the antenatal period rather than during the birth experience; and

(b) Respecting the pregnant woman's fully informed decision, regardless of the subsequent impact this may have on the fetus.

4.3 In a practical sense, the likelihood of a pregnant woman making an informed decision that prejudices the life of her fetus is remote, the relevant legal principles and clinical guidelines reflect a need to ensure that all decisions concerning the prioritisation of treatment between the pregnant woman and the fetus remain entirely with the pregnant woman, assisted by the provision of clear, comprehensive and objective medical advice.

The ethical/moral position

4.4 Although priorities within the maternal-fetal relationship are well established at law and supported by the various guidelines and policies, it would be remiss not to also consider the ethical and/or moral considerations associated with balancing the ethical/moral duty to respect the pregnant woman's right to complete autonomy; and the ethical/moral duty to

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[9] Royal Australian and New Zealand College of Obstetricians and Gynaecologists: Maternal suitability for models of care, and indications for referral within and between models of care. South Eastern Sydney Local Health District Procedure: Women who choose to refuse recommended monitoring and treatment in Maternity Services. QLD Health: Partnering with the woman who declines recommended maternity care. AMA Position Statement: Maternal Decision-Making - 2013.

protect the life of the fetus, the *"utmost vulnerable population"*, for reasons of beneficence, justice and non-maleficence.

4.5 The complexities are no more obvious than in emergency situations where there is a risk of death and/or serious injury to the fetus. In such circumstances, the position at law may conflict with a clinician's ethical/moral duty to take emergency steps to protect the life of the fetus and prevent serious injury. This act becomes particularly critical in circumstances where complications arise during the birth process, or where deviations from the pregnant woman's birth plan or expectations are required for the benefit of the pregnant woman, her fetus, or both.

4.6 In addition to the guidelines previously referred to, there have been specific guidelines and policies developed to assist medical practitioners to navigate this balancing act in those critical moments.

4.7 For instance, in those cases where fetal heart rate monitoring is declined by the pregnant woman, a practitioner can refer to the RANZCOG clinical guideline: Intrapartum Fetal Surveillance, and the NSW Health guideline: Maternity - Fetal heart rate monitoring, to balance their legal and ethical obligations to both parties in the maternal-fetal relationship.

4.8 Similarly, in circumstances where the fetus' cardiotocograph (CTG) is abnormal and it is failing to progress, a practitioner can seek advice and direction from the same guidelines as are outlined above to balance the inherent conflict between avoiding prolonged hypoxia to the baby and the damage that can be caused to a pregnant woman during an instrumental delivery.

5. Achieving greater understanding of the complexities in providing maternity care

5.1 As set out in the policies referred to above, the provision of information and advice to a pregnant woman regarding the labour and delivery processes, including associated complications and possible interventions, are discussions best had during the antenatal phase of the journey.

5.2 This is particularly so given the potential for an emergency to arise in the birthing suite that requires the pregnant woman to engage in quick, informed decision-making and immediate action by her medical team.

5.3 Research undertaken as early as 2019 has recognised that birth preparation in antenatal classes tends to focus on natural birthing methods and the choices the pregnant woman has during birth, and less so on the complications and interventions that potentially lead to trauma[10].

5.4 A focus on normal uncomplicated births is also the focus in websites, in mainstream media and on social media platforms. For example, there is an abundance of information accessible on the website https://www.pregnancybirthbaby.org.au/ about natural birth and normal

[10] Elizabeth Skinner, 'The link between somatic and psychological sequelae of traumatic vaginal birth trauma' (PhD Thesis, The University of Sydney, 2019).

newborn care; however, there is a noticeable absence of information in relation to the complications and interventions that may arise during and after the birthing process.

5.5 Perhaps what is required is a re-evaluation of the education that is provided to expectant mothers during the antenatal phase, to better informing pregnant women about the possible complications, interventions and outcomes of the birth process, not only for the fetus but for themselves. This may ensure pregnant women have greater knowledge about, and a better understanding and awareness of, what to expect during the birth process, thereby reducing the risk of trauma.

6. <u>The mother-baby bond</u>

6.1 Finally, it the Chair's question raises the affect of accidental trauma on the mother-baby bond and may cause long term impacts on the emotional connection that exists between a mother and her child.

6.2 The human species engages in complex, behavioural learning, even in infancy, and bond through attachment. A child develops a bonded relationship to their primary caregiver through complex biological processes and interpersonal relationships over the first year of life. Should there be circumstances where a mother and her baby are unable to engage in immediate skin-to-skin contact after birth for medical or other reasons, it does not necessarily follow that they will never be able to properly establish the mother-baby bond.

6.3 Various measures have been implemented in the vast majority of Neo-Natal Intensive Care Units (**NICU**) throughout Australia to provide family-integrated care to babies. This approach emphasises the important role parents play in looking after their baby. Whilst the baby is in NICU, the parents are encouraged to touch, speak and sing to their baby and to help with their care. Items of the parents' clothing with their smell are placed next to the baby and skin-to-skin contact is encouraged and supported once the baby is in a stable condition.

6.4 Evidence demonstrates that this family-integrated care approach fosters a positive bonding experience between parents and their baby, even when they are temporarily separated.

6.5 As a part of the education that is provided to expectant mothers during the antenatal phase, it may also be helpful to include evidence-based information regarding the establishment of the mother-baby bond.

Yours sincerely

Fiona Davies
CEO, AMA (NSW)